Complaint and grievance procedures must be submitted to the Bureau of Insurance for approval. MCHIPs must file complaint systems for initial approval to the Bureau, and must also file subsequent material changes for approval. In addition, MCHIPs must include a description of their complaint systems with the submission of the annual complaint report. Complaint system filings should include a description of when and in what manner procedures are distributed, and must also document, (procedurally or by including applicable forms), compliance with the following requirements:

REFERENCES	COMMENTS
§ 38.2-5804 A 2	MCHIP enrollee is provided with address and phone number of MCHIP department or contact person to which/whom complaints are to be directed.
§ 38.2-5804 A 2	MCHIP enrollee is provided with mailing address, telephone number and e-mail address of Office of the Managed Care Ombudsman
§ 38.2-5804 A 2	MCHIP enrollee is informed of any required time limits/deadlines for filing grievances/appeals
§ 38.2-5804 A 2	MCHIP enrollee is provided with a clear and understandable description of his/her right to appeal final adverse decisions pursuant to § 32.1-137.15
§ 32.1-137.15 14 VAC 5-215-20 14 VAC 5-215-30	• Notification of results of appeal process must be provided no later than 60 working days after MCHIP receives required documentation • **Final Adverse Decision letter*** must state criteria used and clinical reason for the decision • **Final Adverse Decision letter*** must notify MCHIP enrollee or treating healthcare provider of: o The right to appeal final adverse decisions to the Bureau, pursuant to Chapter 59 of title 38.2 o The procedures for making such an appeal o The binding nature and effect of such an appeal, (specifically, must advise MCHIP enrollee that, except in the instance of fraud, any such appeal may preclude such person's exercise of any other right or remedy relating to such adverse decision. Note, however, that information relating to appeal rights pursuant to ERISA may be included). o Mailing address, telephone number, e-mail address of Office of Managed Care Ombudsman • Copy of the current Appeal of Final Adverse Decision Form must be provided with the **final adverse decision letter***. • Treating healthcare provider can request expedited appeal of adverse decision or adverse reconsideration by telephone; immediate appeal by telephone if appeal regarding prescription to alleviate cancer pain • UR entity shall decide expedited appeal within 1 business day of receipt of all necessary documentation * *Note: Final adverse decision letters must be sufficiently clear so as to communicate to the recipient that this notification represents the company's final decision*.
14 VAC 5-215-50 I	When an expedited appeal is reviewed by the UR entity and denied, procedures must document that notification of denial to appellant will include his right to request an expedited appeal with the Bureau of Insurance. This notification will be immediately provided by phone, fax or e-mail to person who requested the appeal, followed by written notification within 24 hours to appellant and treating healthcare provider, with accompanying forms for filing the appeal. *Note: this written notification is considered a final adverse decision letter, and must include the required elements noted above.*

REFERENCES	COMMENTS
14 VAC 5-215-50 J	When a *request* for an expedited appeal has been denied by the UR entity, procedures must document that appellant will be immediately notified of the decision and of his right to request an expedited appeal with the Bureau of Insurance. This notification will be immediately provided by phone, fax or e-mail to the person who requested the appeal, followed within 24 hours by a written notification to the appellant and to the treating healthcare provider of the right to appeal with accompanying forms for filing the appeal. *Note: this written notification is considered a final adverse decision letter, and must include the required elements noted above*.

Additional Requirements:

§ 38.2-5803 A 3 14 VAC 5-211-210 (HMOs only)	The information concerning the method of resolving complaints that is provided to covered persons at the time of enrollment or when EOC is issued, and made available upon request annually thereafter, along with documentation supporting processes MCHIP has in place to comply with this requirement. *Note: Approval of the EOC is a separate function within the Bureau. Action taken in connection with the complaint system filing is simply to ensure consistency and clarity and does not constitute an approval or disapproval of the EOC or any documents subject to filing and approval requirements pursuant to §§ 38.2-316 and 38.2-4306 of the Code of Virginia..*

§ 38.2-5804 A 1 § 38.2-511	Documentation to support that MCHIP will maintain complete record of written complaints from the policyholder/subscriber or claimant for no less than 5 years, including: • Total number of complaints • Classification by line of insurance • Nature of each complaint • Disposition of complaints • The time it took to process each complaint
§ 38.2-5804 C	Documentation to support that the MCHIP will maintain and submit all information specified in § 38.2-5804 C, in conjunction with its annual report submission, (which includes complaint information identified above as well as the number, amount and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers).